MARIPOSA COMMUNITY HEALTH CENTER

COVID -19 Vaccine Consent Form

PLEASE PRINT

Name *Last*	*First*	*MI*	**DOB**	**Age**	**Cell Phone Number** ( )

Address	*Apt#*	**City**	**State**	**Zip Code**

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian/Other Pacific Islander ☐ Black or African American ☐ White ☐ Other Race

Ethnicity: ☐ Hispanic ☐ Not Hispanic or Latino ☐ Unkown

COVID-19 Screening Questions	**YES**	**NO**	**DON'T KNOW**
1. In the past two weeks, have you tested positive for COVID-19 or are you currently being monitored for COVID-19?	☐	☐	☐
2. In the past two weeks, have you had contact with anyone who tested positive for COVID-19?	☐	☐	☐
3. Do you currently or have you in the past 14 days, had a fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, nausea, vomiting, or diarrhea?	☐	☐	☐

Immunization Screening Questions	**YES**	**NO**	**DON'T KNOW**
1. Are you sick today? (for example: fever, cold congestions)	☐	☐	☐
2. Do you have allergies or reactions to any foods, medications, vaccines or latex? (for example: eggs, gelatin, neomycin, thimerosal, etc.)	☐	☐	☐
3. Have you ever had a serious reaction after receiving a vaccination? Do you have a history of fainting, particularly with vaccines? Has any physician or other healthcare professional ever cautioned or warned you about receiving certain vaccines or receiving vaccines outside of a medical setting?	☐	☐	☐
4. Have you received any vaccinations or TB skin test in the past 4 weeks? Do you plan to receive any vaccinations in the next 4 weeks?	☐	☐	☐
5. In the past 90 days, have you received a transfusion of blood or blood products, including convalescent plasma?	☐	☐	☐
6. Do you have cancer, leukemia, HIV/AIDS, rheumatoid arthritis, ankylosing spondylitis, Crohn's disease or any other immune system problem?	☐	☐	☐
7. Do you have a weakened immune system or in the past 3 months, taken medications that weaken it such as cortisone, prednisone, other steroids, anticancer drugs, or radiation treatment?	☐	☐	☐
8. For women, are you pregnant or is there a chance you could become pregnant during the next month? Are you currently breastfeeding?	☐	☐	☐

I have been given a copy and have read, or have had explained to me, the information in the Vaccine Information Sheet(s) for the COVID-19 vaccine. I have had a chance to ask questions which were answered to my satisfaction. I understand the benefits and risks of vaccination. I understand that I should remain in the clinic for 15-30 minutes after vaccine administration to be monitored for any potential adverse reaction. I ask that the COVID-19 vaccine be given to me or the person named on this health record for whom I am authorized to make this I agree to the health care provider giving vaccinations to release information about the COVID-19 vaccine given to myself or the person for whom I am authorized to consent to the Arizona State Immunization Information System (ASIIS), other health care providers and schools in order to avoid receiving any unnecessary vaccination and to provide information about what immunization I have received.

x _____ _____

Patient signature/Guardian signature Date

For Office Use Only

_____ _____ _____ _____ ☐ Right Deltoid ☐ Left Deltoid

Date of Vaccination Vaccine Manufacture Lot Number Expiration Date

_____ _____

Vaccine Administrator (Print) Vaccine Administrator (Signature)